BETSY LEHMAN CENTER
for Patient Safety and Medical Error Reduction

Summary of Research Findings

The Public's View on Medical Error in Massachusetts*

Harvard School of Public Health **Lead Investigator: Bob Blendon, ScD**

Purpose: The consumer voice is often missing from discussions about medical harm. Harvard School of Public Health conducted a public opinion survey to measure awareness, attitudes, and behaviors related to patient safety in Massachusetts.

Methods: More than 1,200 Massachusetts adults were interviewed by telephone (land lines and cellular phones). The randomly-selected sample was divided equally among four geographic regions that cover the entire state. The survey took place from September 2 – 28, 2014.

Findings:

Frequency and causes of medical errors:

- **Nearly one-quarter of Massachusetts residents (23 percent) reported that they or someone close to them experienced an error during their medical care at least once during the last five years**. This figure is consistent with several other sources of data on the extent of patient harm.
- More than half of those who experienced an error said the error resulted in **serious health consequences.**
- The most common type of medical error was a **misdiagnosis**, with 51 percent reporting that they or someone close to them was incorrectly diagnosed. In addition, 38 percent of respondents described the error as a result of **incorrect tests, surgeries or treatment**.

Reporting errors:

- Among those who had an experience with medical harm, **54 percent reported the error to someone**, most typically to someone working at the facility where the error occurred.
- The vast majority, 90 percent, said they reported the error because they **wanted to prevent the same thing from happening to someone else**. Also, 17 percent said they were motivated by a desire to receive compensation for harm caused by the error.
- Among those who did not report their experience, 65 percent **did not believe it would do any good** and another 36 percent said they **did not know how to report** the problem.

General awareness around patient harm:

- Before a definition of medical error was read to them, only **43 percent of respondents were familiar with the term**.
- Medical errors were considered a **"very serious" or "somewhat serious" problem** in the state by 35 percent of those polled.
- A majority of Massachusetts residents believe that **there little or no differences** between hospitals when it comes to the frequency of medical errors.

* This report was commissioned in collaboration with the Health Policy Commission.

Patient Safety in the Commonwealth of Massachusetts: Current Status and Opportunities for Improvement
RAND Health **Lead Investigator: Eric C. Schneider, MD, MSc**

Purpose: Rand Health conducted an extensive series of key informant interviews about patient safety in Massachusetts to chronicle changes over the past two decades, to identify the most pressing challenges today, and to explore opportunities for significant reduction in medical harm.

Methods: Researchers held in-person or telephone interviews with more than 40 key Massachusetts stakeholders, including health care quality and patient safety experts; hospital patient safety officers; leaders of ambulatory centers, outpatient practices and long term care facilities; patient and family advisory councils; state agency/committee representation; and patient safety and advocacy organizations. After asking participants a series of open-ended questions, RAND used quantitative analysis to identify thematic trends from the interviews and qualitative methods to describe gaps in patient safety in Massachusetts.

Findings: Over the last 20 years, awareness of patient safety within the Massachusetts medical community has grown. A number of providers, particularly hospitals, have made great strides in reducing the incidents of harm to patients. However**, progress has not been consistent across all hospitals and especially across the entire continuum of care**. Approaches that can reduce the risk of harm to patients in hospitals have not been well adapted or pursued equally in doctors' offices, community health centers, long-term care facilities, ambulatory surgical centers, and other care settings.

Risks to individual patients:

- The report identifies a series of **early risks** that have been reduced—thought not entirely eliminated-- in hospitals over the last 20 years. These **well-understood, mostly preventable risks** include infections acquired during the course of care as well as surgical lapses, such as wrong site surgeries.
- Also described are a number of **persistent risks** that have been difficult to curtail, including patient falls in hospitals or other supervised medical settings. Medication errors persist, as do pressure ulcers that result from lengthy stretches of time in bed.
- **Newly-apparent risks** have become more visible in recent years and are primarily seen in non-hospital settings where there has been less research about patient harm, fewer protocols developed to reduce errors, and safety challenges unique to each setting. **Diagnostic errors** are among the most pressing of the emerging risks; concerns about harm that can result from **poor coordination** when an individual transitions from one care setting to another were also expressed.

Risks related to organizational characteristics and capabilities:

- **Lack of viable safety culture and leadership on patient safety: Awareness** about patient safety has largely improved over the last 20 years and, for some institutions, a strong **patient safety culture** has developed. However, there are many settings where the **leadership** has failed to take a proactive role in setting patient safety as a top priority. **Cost containment** pressures have also distracted many providers from pursuing "zero harm" goals.
- **Lack of patient centered care: Patient engagement** in care decisions is considered vital to reducing harm, but has proven difficult to implement. Tools to improve patient-provider communication are needed; patient and family advisory committees could be utilized more broadly and effectively.
- **Health information technology:** Health IT, **particularly electronic health record systems,** have not yet improved internal and cross-provider communications as hoped. Many systems are cumbersome; key information about a patient can be easily overlooked in the complex formats of health record systems.
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- **Lack of non-standardized care**: Adherence to **standardized protocols** is a proven way to reduce risks, but there is much variation in the degree of success in standardizing care in Massachusetts hospitals and other institutions. Even when standard protocols are in place, too many clinicians resist adherence.
- **Workforce availability and capability:** Staffing issues, including a **shortage of qualified health care workers** is also a concern for patient safety. In some instances, demands outstrip the workforce supply. In others, financial pressures drive providers to minimize staffing. Provider **inexperience with complex patient needs** was also cited as a safety concern.

Risks related to policy influences:

- **Payment policy:** Policies for reimbursing medical care providers, especially for hospitals, may not offer sufficient incentives to prioritize patient safety. Incentives tied to **greater care volume** or **patient satisfaction scores** may also shift resources toward marketing and amenities and away from less visible efforts to improve care.
- **Lack of coherent reporting program:** Health care facilities report certain serious medical errors to regulators, but there are mixed views about the efficacy of the data collection systems. The value of **transparency** and public reporting of patient harm remains controversial in Massachusetts. Also, information about safety - as it is currently collected and disseminated - is of **limited use to consumers** making decisions about where to seek care.
- **Poorly-designed regulatory and accreditation oversight:** Overlapping responsibilities for patient safety may also put patients at risk. Some stakeholders believe the regulatory environment is too weak, while others said the state is making more of an **effort to support safety improvements in health facilities**. The Joint Commission National Patient Safety Goals program was credited with focusing hospital leaders' attention on safety.

The report concludes with a series of key questions to guide **the design of an organized effort** to reduce patient harm in Massachusetts:

1. How should actions that can make care safer be prioritized and coordinated among participating organizations and professionals?
2. How should measurement reporting be used?
3. How can alignment be achieved among federal requirements, accreditation standards, state regulations, and organizational policies?
4. How should patients, caregivers, and the public be engaged in patient safety?

Adverse Event Reporting in Massachusetts and Other States
National Academy for State Health Policy (NASHP) Lead Investigator: Jill Rosenthal, MPH

Purpose: The National Academy of State Health Policy conducted a national survey of state adverse event reporting systems and patient safety policy initiatives. Its report offers insight into how Massachusetts' policy and regulatory approaches to data collection and dissemination of information regarding adverse events compare with practices in the other states.

Methods: NASHP fielded a 17-question online survey of officials in states with adverse event reporting systems. Researchers identified updates to reporting systems since NASHP's 2007 survey on the same topic, and collected information about each state's approach to collecting data about these medical errors. In addition, NASHP conducted phone interviews with a few key informants in Massachusetts and four other states to learn about patient safety innovations and broader collaborative work on patient safety.

Findings:

- **Twenty-six states and the District of Columbia have reporting systems to monitor occurrence of adverse medical events, a number that has not changed significantly since NASHP's survey work in 2007.** Momentum to establish a nationwide, mandatory reporting system for state governments to collect standardized information about adverse medical events - fueled by the seminal Institute of Medicine report, *To Err is Human*, in 1999 – has stalled.
- **Massachusetts is the only state with two distinct adverse event reporting systems that require reporting from some of the same facilities.** Streamlining, coordinating, or potentially consolidating reporting processes across the two systems could help address provider concerns about reporting burden. Pennsylvania offers an example of how Massachusetts might consider automating and integrating data processes to enable multiple entities to respond to adverse event reports without duplicating efforts.
- **A formal or informal system evaluation as was conducted by Minnesota might help Massachusetts stakeholders understand the impact of its reporting systems on provider awareness, trust or other patient safety issues.** It could also inform strategies for improving provider experience with the two systems.
- **Despite complementary goals, adverse event reporting systems in Massachusetts and elsewhere seem to stand alone from states' broad quality improvement, cost containment, and other delivery system reforms.** Massachusetts has an opportunity to explicitly integrate adverse event reporting system data or patient safety more broadly into activities under Chapter 224 of the Acts of 2012 or in grant activities such as SIM.
- **Regulators across the country believe that adverse event reporting systems give them valuable information,** even though the systems were not designed to measure the full extent of medical harm. Most state systems are limited to information about a subset of events that cause serious patient harm, and officials acknowledge underreporting of these errors remains a problem.
- Finally, like Maryland or Pennsylvania, **reporting system officials in Massachusetts could partner with other entities in the state** to produce patient safety events, initiatives or learning collaborations that leverage reporting system data to address specific areas of need.